

IMPLEMENTING CULTURAL COMPETENCE IN THE HEALTH CARE ORGANIZATION  
RECOMMENDATIONS FOR PLANNED PARENTHOOD HEALTH SYSTEMS

by

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### Abstract

Cultural competence in health care organizations is a way to extend to patients from every culture or ethnic background equal access to quality health care. Constantly shifting demographics are changing the health care needs of communities; language and culture barriers have the potential to create enormous gaps in health care for members of racial and/or ethnic minority groups. This study explores similarities of culturally competent health care organizations and examines their keys to successful implementation. Leadership buy-in and self assessment as essential steps are explored and several models of delivery are reviewed. Barriers in this process are also examined and discussed and then recommendations on cultural competence implementation for private health care organizations are given. Specific recommendations are made to Planned Parenthood health services programs that can be extended to other health care organizations.

On Sunday March 23, 2008, Kara Neumann, 11, died in her family's home in Wausau, Wisconsin. Her death was related to complications of undiagnosed and untreated type-1 diabetes. Her parents knew she was sick but not why, because she had not visited a doctor since she was three. They chose instead to put their faith in God and pray for the return of her health ("Child's Death," 2008). Would the child still be alive if the parents knew of a health care provider who would be able to understand their position on prayer and healing and was respectful of it?

### Introduction

An increasingly diverse and multicultural society challenges health care organizations and providers to consider culture as it influences health. Health care providers across the country can conceive that culture and language may influence individuals' health, healing, and wellness belief systems. What may be less clear to these same providers is how illness, disease, and their causes are perceived by the patient and how treatment is given and by whom. Help-seeking behaviors and attitudes toward health care providers and how rights and/or protections are exercised by individuals from other cultures may be mystifying to health care providers, thereby creating an environment, as possibly seen by the patient, as one that is wrought with judgment. Whether it is perceived or real is of little consequence because to the patient it is the same. Every health care provider has his or her own biases which distort the lens through which they view their world. Furthermore in 2002, an Institute of Medicine report presented compelling evidence that "minorities tend to receive lower-quality health care than whites do, even when insurance status, income, age and severity of conditions are comparable". *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* is a comprehensive study of health disparities in

the United States. "Although myriad sources contribute to these disparities, some evidence suggests that bias, prejudice, and stereotyping on the part of health care providers may contribute to differences in care" (Institute of Medicine, 2002). Because of this, organizations are looking at ways to increase cultural and linguistic competence among their employees and systems as a way for their providers to better understand how culture impacts health and how transcending these diverse beliefs can lead to equal access and quality health care (Ahmann, 2002; "Cultural Competence," 2001; Harlan, Lecture, 2007).

Cultural and linguistic competence can be defined as the ability of health care providers and health care organizations to meet the social, cultural and linguistic needs of patients that present with diverse values, beliefs and behaviors (Betancourt, 2002). Cultural competence has been defined in multiple ways and is often described as having knowledge, awareness, and sensitivity to the meaning of culture and as respect for differences with a desire to learn. However the most common referenced definition across time and disciplines is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" (Cross, T., Bazron, B., Dennis, K., & Isaacs, 1989).

Why is this important? In 2000 31% of the population was identified as a racial or ethnic minority, and this is expected to increase to 40% by the year 2030 and to 50% by 2050 (US Census Bureau, 2000). Currently the United States Census Bureau ("Population clocks," 2008) estimates the population of the United States to be 303,768,485 people. In addition to ever increasing percentages, health disparities including diabetes, heart disease, stroke, drug and alcohol abuse, and cancer persist in racial and ethnic minorities (IOM, 2002). If there is any language or cultural barrier that prevents even one percent of the racial or ethnic minority

population, over 940,000 people, from seeking, having equal access to or obtaining quality health care, the potential costs in terms of early morbidity and mortality would be great.

“Failure to understand and manage social and cultural differences may have significant health consequences for minority groups in particular” (Betancourt, Green & Carrillo, 2002, p. V).

Putting aside the issue of addressing health disparities and taking into account the increase in the population in general, becoming a culturally competent health care organization could become a must from a business perspective just by looking at the law of supply and demand. In a community where there is a large population of racial and ethnic minorities but few culturally competent health care providers, there is high demand and low supply. Providing culturally competent care to this population helps to increase the supply to meet the demand, and it increases the population base from which an organization could recruit patients as well as employees, thereby securing a larger portion of the market share of both. Providing a culturally competent environment internally provides a place where cross-cultural employees can contribute fully to the agency’s overall success by offering their own experiences and perspectives (Van Ngo, 2000).

Planned Parenthood Health Systems (PPHS) in Raleigh, North Carolina, through their self-assessment process, identified a significant need in their community. The Latino population was being underserved for reproductive health; based upon the results, the leadership of the Raleigh health center developed a plan to address this need. In an effort to fund this plan, PPHS applied for and received money that allowed them to expand their patient population and service provision (“Breaking Cultural Barriers,” 2007). Providing culturally competent care allowed the health center to obtain funding that would have been inaccessible otherwise.

Planning for cultural competence, which assures appropriateness of care to diverse populations, is a lengthy process that requires time, energy and resources from the stakeholders (board of directors, agency staff and leadership, clients, and community). Some organizations have done this successfully and completely and are considered models for the masses while some never get out of the planning phase. What keys to implementation did the first group possess and what barriers did the second group face?

### Literature Review

#### *Exemplary Components of Culturally Competent Care*

According to the Health Resources and Services Administration (HRSA) (2001), programs that deliver successful culturally competent care demonstrate these exemplary practices: “define culture broadly, value clients’ cultural beliefs, recognize complexity in language interpretation, facilitate learning between providers and communities, involve the community in defining and addressing service needs, collaborate with other agencies, professionalize staff hiring and training, institutionalize cultural competence” (Health Resources and Services Administration, 2001, p. 11).

Culture is widely understood as something a group of people of a specific race or ethnicity possess such as a particular language. Because health care is administered on an individual case by case basis, other factors besides language affect the delivery of the service. Every individual has experiences or beliefs that differentiate her from others of her narrowly defined culture of race or ethnicity. Because of this, it is necessary to define culture in the broadest terms that would include not only race, ethnicity, language, but also more specific experiences such as gender roles, level of education, personal trauma, or sexual orientation (HRSA, 2001).

Migrant Health Services of Community Health of South Dade, Inc. in Miami, Florida targeted migrant farm workers in an effort to increase males' access to health care while decreasing barriers to health care for mothers and their children. They recruited and trained outreach workers from their target community and utilized the inherent cultural knowledge of those workers to help them teach their community members about family planning and reproductive health. This program experienced success as demonstrated by a 110 percent increase in males who sought health care services and 54 percent of women who reported feeling more comfortable seeking family planning services (HRSA, 2001).

Each culture has its own set of beliefs about health care in general. Learning to value these beliefs is an important component of successful delivery of culturally competent care. Being aware of, understanding and valuing cultural beliefs of target communities allows providers of care to know how to discuss issues including substance abuse, violence, mental health, and sexuality with patients. Awareness and understanding also prevents providers from reacting in a negative way if a patient chooses to share their beliefs about a particular health issue (HRSA, 2001).

The Perinatal Program, a program of La Clinica del Carino Family Health Center, Inc. of Hood River, Oregon, effectively combines cultural beliefs and sound medical care as demonstrated by their handling of a belief in Hispanic culture that a sunken soft spot on a baby's head should be filled back in by holding the baby upside down and shaking it gently and briefly. The medical belief about this is that it is caused by dehydration. The providers in this clinic value the belief by telling parents to give the baby lots of liquid in the form of breast milk, formula or water in addition to turning it upside down and shaking it. The value of the belief is upheld and the child gets appropriate medical attention (HRSA, 2001).

Effective communication between patient and provider is critical to the success of the visit; language is more than words. Sharing the patient's language is not enough for effective communication. There must be an understanding of context, variation of meaning of words across cultures that share the same language, and an awareness of varying literacy levels of patients. Translating information from one language to another is more than choosing the word that means the same thing in the patient's language of choice. This can result in miscommunication as the word the patient hears might have a different cultural meaning than the one intended by the provider. It is not necessarily a concrete translation of the provider's words that is required, but a general message including the important details delivered in a way the patient can fully comprehend. Vista Community Clinic's Medical Interpretation and Cultural Competence program of Vista, California addresses literacy and illiteracy issues by screening and modifying every piece of written communication given to patients with limited or no literacy in their first language (HRSA, 2001).

Facilitation of learning between providers and patients is a method by which each party in the interaction can learn about the other. Providers must learn about their patients' belief systems, general knowledge and attitudes toward health care in the United States, and the broad definitions of their patients' culture. In turn, the patients must work to understand how health care is administered in the United States, as well as how the overall delivery system works. This process can help both sides understand what their role in attaining culturally competent care is. Participation by the patients will eventually improve their access to quality care in their community. Parents of children with disabilities began a program called Parents Helping Parents in Santa Clara, California and created a successful example of this component. This group facilitated efforts to educate health care providers on how to create family-centered care. A



health maintenance organization has assisted with the institutionalization of these efforts by requiring providers to participate in a training focused on care, collaboration with families and cultural competence (HRSA, 2001).

Involvement of the community in defining and addressing service needs means that community members from the target community will assist in every stage of the process, from self-assessment all the way through implementation of a plan and beyond to evaluation of the efforts. Programs or agencies that are successful with this component place community members in voting positions on advisory councils or boards of directors. These same organizations also solicit community input through focus groups, interviews or town meetings, then use the information in their shift toward cultural competence (HRSA, 2001).

Collaboration between agencies can help agencies overcome barriers in the quest for cultural competence. For example, agencies in small communities may not have the resources to secure interpreter services for their non-English speaking patients or there may not be qualified interpreters to fill the need. The Tri-County Health Center in Newton Grove, North Carolina, through collaboration with other agencies throughout the state that serve Spanish speaking individuals, created an effort that eventually established a state-wide interpreter service that happened over the telephone. The service is grant-funded and provides free professionally-trained interpreters to communicate between providers and patients. This collaboration between agencies allows organizations and patients in smaller communities to access tools that will ensure more culturally competent care (HRSA, 2001).

Approaching hiring and training with professionalism is a way to communicate to current and potential staff the agency's commitment to cultural competence. If cultural competence curriculums and trainings are considered by leadership to be crucial to the professional

development of agency staff, these will become part of the performance review process and will be communicated as requirements of employment. The production of training materials and setting aside time and money for trainings helps the agency establish cultural competence as an essential clinical skill. This key component is one part of institutionalizing cultural competence. To institutionalize an effort such as cultural competence, it must be infused throughout the agency from strategic planning at every level and staff development activities to allocating funding resources. Once it is integrated into everything the agency does, everyone in the agency becomes aware and accountable for delivering culturally competent care (HRSA, 2001).

#### *Self-Assessment's Role in the Process*

Self-assessment is a method in which agencies or organizations examine themselves and their entire infrastructure including “attitudes, practices, structures and policies of programs and their personnel” (“Tools and,” n.d.; Mason, 1995). Self-assessment is an effective and systematic way to plan for and incorporate cultural competence within an organization. Self-assessments must include everyone involved with an organization, including staff and board members, clients/patients, and community members. The self-assessments will be used to gather important information about the organization; once the information is gathered, policy development can begin. (Goode & Jackson, 2003; Mason, 1995; Reid-Rose, n.d.). This allows perspectives from the inside and out of the organization to be considered in future plans and trainings. The results from the assessment will identify areas of strength and need and will be used to set the direction in which the organization and its employees can grow toward cultural competence (Goode, Jones & Mason, 2002). In short, these assessments will help members at every level of the organization, from upper management to frontline workers, learn what it is they do not know. Self-assessment tools are limited by the organizations that use them. If the

leaders of the organization fail to use the assessment results to push forward their efforts to become culturally competent, the tool becomes useless (Van Ngo, 2000).

Self-assessments can take a variety of forms: checklists, questionnaires, surveys, focus groups, personal interviews, group interviews, frameworks with indicators, and document and policy review (Mays, de Leon Siantz, Viehweg, 2002; "Tools and," n.d.; Linkins, McIntosh, Bell & Chong, 2002). (See Appendices A, B & C.) These tools are available in standard forms from organizations such as the National Center for Cultural Competence or the United States Department of Health and Human Services; they can also be created within an organization by an internal quality improvement team of individuals using the National Standards for Culturally and Linguistically Appropriate Services in Health Care (See Appendix D). This assessment team or committee would be "comprised of board members, administrative and program staff, clients and community members" (Van Ngo, 2000, p. 22). This multidisciplinary team of individuals would be responsible for the creation and administration of the assessment tool, compiling the results and presenting them to the organization's members, planning next steps and leading the overall cultural competency initiative (Van Ngo, 2000; Zambrana, Molnar, Munoz, & Lopez, 2004).

Because of the level of involvement from the employees of the organization, the leadership, and members of the greater community, it is important to communicate the significance of the self-assessment process and what role it plays in creating change that has the potential to affect the entire community. Participants engage in the structure of self-assessment more completely when they fully understand what the purpose for the assessment is, how the results will be used and for what gain to the community, and what their roles in the process are. Once the assessment process is complete, successful organizations share the results with all of

the participants in different ways depending upon their role in the organization or community.

Some of these include:

- “Comprehensive reports and executive summaries,
- Power Point presentations,
- Conference calls,
- On-site program and workgroup consultations,
- Town Hall style meetings, and
- Strategic planning sessions” (Goode, Jones & Mason, 2002).

These methods of delivery encompass several learning styles and environments and, along with appropriate interpreter services, allow participants to access the results equally.

The assessment of cultural competence should not be considered an isolated event, but rather a continuous process that is emphasized and integrated in an organization's overall quality improvement activities. Members of every level of an organization must be assessed, at the beginning and throughout the process, so a complete picture of the culture of the entire organization can be developed. Every effort should be made to include “people from diverse racial, ethnic, religious and linguistic backgrounds in each aspect of the assessment process” (Van Ngo, 2000).

The information provided by individuals in the self-assessment process will help the leadership understand the culture of their own encapsulated organization. If the employees of an organization represent different cultures and ethnicities, that organization's internal culture is subject to the same “cross-cultural dynamics, misinterpretation and misjudgment” that happens outside in the greater community (Mays, de Leon Siantz, Viehweg 2002). Once the barriers and challenges to cultural competence are identified within an organization, the leadership and

assessment team can determine what trainings and strategies are necessary to overcome those challenges.

An example of fostering inclusiveness comes from the Asian & Pacific Islander Coalition on HIV/AIDS (APICHA) BRIDGES Project in New York City. This agency conducted interviews of their own staff and peer advocates in an effort to learn more about the greater community. These interviews revealed problems within the agency's culture. Staff members needed more encouragement and mentoring by supervisors and more chances to share their experiences and obtain advice on challenging cases (HRSA, 2001).

A Planned Parenthood program in New York City provides an example of an agency that embodies cultural competence inwardly and outwardly. Their program is called Project Street Beat and it developed some level of internal cultural competence by employing members of the community they serve in positions throughout the project. In another effort to serve their community completely, they recruited peer advocates who had been clients of the program. Because the peer advocates had similar experiences to those they were educating, they were able to draw parallels between their own lives and those of the individuals they were working to educate (HRSA, 2001).

Because cultural competency implementation is a dynamic process and demographics are constantly shifting, stakeholders should be assessed at regular intervals. These assessments will generate data which will show progress toward the goals of achieving cultural competence as well as areas for continued improvement. The collected information can be applied to continually improving the quality and content trainings and services offered by the agency. The assessment process allows health care organizations to move toward fully inclusive cultural competency (Chinman, Imm, Wandersman, Kaftarian, Neal, Pendleton & Ringwalt, 2001).

### *What is Leadership's Role*

In describing the role of leadership as it relates to attaining cultural and linguistic competence, the National Center for Cultural Competence determines the goal “of leadership is to influence, motivate, and enable the contributions of others to advance and sustain cultural and linguistic competence within their respective organizations and programs, within communities, and/or among groups and constituencies of which they are members” (Goode, Jones, Dunne & Bronheim, 2007, p. 26). The support of the leadership of any health care organization is imperative to successful implementation of a cultural competence model. The leadership is rarely one person; instead it includes all decision makers including board members, chief executive officers, and all levels of upper management and middle management. Sometimes any person with influence should be included. These leaders set the stage for the entire process and without full support, little progress will be made (Shaw-Taylor, 2002; McPhatter & Ganaway, 2003).

Noted across many studies about cultural competence is the idea that all individuals within an organization must submit themselves to the process of becoming culturally competent, especially all levels of leadership. Their commitment and involvement lays the groundwork upon which the rest of the members of the organization will build (Betancourt, Green & Carrillo, 2002; Campinha-Bacote, 2002). Once commitment is secured, becoming culturally competent begins with a realistic self-assessment that illustrates the starting point of the organization and its stakeholders. Using this information the leadership is responsible for developing a realistic plan with expectations that will guide the progression of change (McPhatter & Ganaway, 2003).

### *What Leadership Role Does Public Health Have?*

Assessment, policy development and assurance are the three core functions of public health and these functions were described by the Institute of Medicine in 1988.

These descriptions are:

- Assessment – “every public health agency regularly and systematically collects, assembles, analyzes and makes available information on the health of the community, including statistics on health status, community health needs and epidemiology and other studies of health problems” (Institute of Medicine, 1988, p. 7).
- Policy development – “every public health agency exercise its responsibility to serve the public interest in the development of comprehensive public health policies by promoting use of the scientific knowledge base in decision-making about public health and by leading in developing public health policy” (IOM, 1988, p. 8).
- Assurance – “public health agencies assure their constituents that services necessary to achieve agreed upon goals are provided, either by encouraging actions by other entities (private or public sector), by requiring such action through regulation, or by providing services directly” (IOM, 1988, p. 8).

Shaw-Taylor (2002) identifies the importance of public health’s role in achieving culturally competent care by drawing the connection between public health and standard twelve of the National Standards on Culturally and Linguistically Appropriate Services (CLAS). Standards four, five, six and seven are federal mandates for health care organizations that receive funds. The remaining standards are guidelines for providing culturally competent care. Standard twelve says health care organizations should work together with communities using a variety of methods to promote participation of community members in creating and integrating cultural competence activities (Office of Minority Health, 2000).

Public health leaders have a mandate that states part of their function in their community is to assist in preparing for the future. As a result of this, strategic planning consumes much of their time and energy (Rowitz, 2001). The connection between culturally competent care and public health becomes clear when considering the Public Health Leadership Principles as described by Rowitz (2001). The second principle says “the goal of public health is to improve the health of each person in the community” (Rowitz, 2001, p. 6).

If an entire community of individuals experiences barriers in obtaining culturally competent care, the overall health of the community suffers. While it may be privately held health care organizations that are working towards cultural competence, their inability to provide quality care to the community members affects the greater community and that makes it priority for public health leaders.

Assessment of community health and existing or future needs is one of many responsibilities public health bears already, so providing that information to health care organizations could assist them in attaining their goals more quickly. While public health leaders often begin the process, it is important to include members of the community to get the best information possible (Rowitz, 2001). The addition health care organizations to this effort provide another dimension of information to the assessment process.

Policy development within communities often happens through coalitions made up of organizations and public health leaders that are targeting a specific problem such as health disparities among minority populations. Once the assessment phase is complete and the information assimilated, the coalition can begin strategic planning to decide what steps are needed to address the problem. Strategic planning is directed toward meeting goals that were determined to be solutions to the problem (Rowitz, 2001). Public health leaders could help



health care organizations align their goals with the overall health goals and objectives of the community (Shaw-Taylor, 2002).

Assurance is the third core function of public health. One major aspect of this function for public health leaders is implementation of programs which literally is the translating of plans and policies into services provided to the community (Rowitz, 2001). This function aligns itself with cultural competence implementation. Once the planning phase is complete, agencies must move those plans into action so community members can have access to equal and quality health care.

#### *Models for Delivery of Cultural Competence*

Models of delivery are plentiful throughout the literature. Each model has between three and five constructs and each model is structured to fit the discipline from which it came. Campinha-Bacote (2002) describes a model of delivery for cultural competence that is based upon the following five constructs: “cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desires” (p. 182). The first three constructs work toward developing levels of information. Cultural awareness describes discovering information about one's self in an effort to determine prejudices and existing biases. Developing cultural knowledge is a procedure through which an individual would learn about other cultural and ethnic groups. Cultural skill encompasses learning to conduct cultural and physical assessments of individuals (Campinha-Bacote, 2002).

The fourth construct, cultural encounter, is the evolution of spending time with a person of a different culture. This interaction provides a way for providers to develop their own experiences with that particular culture as well as dissolve any previously held stereotypes. Campinha-Bacote (2002) also warns that, because it is an interaction with only one person of a

particular culture, they do not necessarily embody the values or practices of the entire culture.

The fifth construct, cultural desire, seems to be the basis of the first four constructs. This construct addresses the achievement of cultural competence as a genuine internal drive instead of an external push, and that action is the most important aspect of the construct. Overall, the model is built in a way in which participants must experience all five constructs no matter what their starting point in their journey toward cultural competence (Campinha-Bacote, 2002).

An example that closely follows this model of delivery is from L.A. Care Health Plan in Los Angeles, California. The move toward cultural competence began once the results from an agency-wide survey were compiled. Employees who had direct contact with patients were less satisfied with their jobs than those who had little or no patient contact. These results were presented to the leadership along with suggestions for cultural competence trainings. The data were the key to gaining support for the process. Data collected after the training was complete showed positive reactions from the employees. This same data was the catalyst for the agency to re-evaluate personnel practices and to integrate cultural competency trainings as an ongoing process. They also added to their contracts with other service providers that they, too, must demonstrate culturally competent health care practices (Wu & Martinez, 2006).

Van Ngo (2000) introduces another model of delivery. This model involves six phases of the process: starting point, community consultation, internal assessment, planning for change, implementation, and evaluation/outcome measurement. This model has more specific actions listed and, unlike Campinha-Bacote's model, would be followed beginning with phase one.

- Phase one is about preparation. In this phase, organizations would garner support from stakeholders or the leadership, identify the issues, and develop a plan with short- and long-range goals. It also involves beginning training on various cultural

issues as well as implementation of some changes.

- Phase two is an information gathering (e.g. demographics) and a relationship building stage. Relationships include having meetings with community members to uncover the issues they face when receiving health care and involving them in the planning process for the organization's overall mission.
- Phase three is about self-assessment. In this phase the leadership, including community members, would scrutinize every aspect of the organization's operation from hiring practices to service delivery to find barriers to culturally competent care.
- Phase four is planning for change. This phase is about policy development, specific steps toward cultural competence through an action plan, and revealing the findings from the self-assessment. Obtaining leadership support in order to progress would happen in this phase.
- Phase five is actual implementation of the policies, trainings, and strategies developed in the previous four phases.
- Phase six is the evaluation of the implementation that occurred in phase five. This involves data collection and review from the first five phases then implementing changes based upon the results of that data collection.

This model is one that assumes there is no end to achieving cultural competence. The self-assessment process is constant and the organization is continuously responsive to the results (Van Ngo, 2000).

Children's Hospitals and Clinics in Minneapolis and St. Paul, Minnesota provide an example of the previous model. This organization is the eighth largest health care organization

for children in the country. Their change process was instigated by a lawsuit concerning access to care by deaf patients as well as a change in leadership. They began with only two interpreters that has since grown to fourteen. These interpreters have also acted in the capacity of patient advocates during interactions between providers and patients. Informal survey results show positive reactions from the patients and their families. The leadership has made these changes part of their institutional culture and their patient load has increased due to efforts to educate community members about their language services (Wu & Martinez, 2006).

### *Why Is Everyone Not Doing It?*

In a process as lengthy and involved as cultural competence implementation, it is logical to surmise there would be barriers and challenges that each organization would face. While there are not large numbers of barriers, the same ones are listed consistently throughout the published literature. The common list of these include: lack of awareness, knowledge, skills, time, resources and organizational support, and prejudice (Shaw-Taylor, 2002; Sue, 2001; Leonard & Plotnikoff, 2000).

The National Center for Cultural Competence published a list of suggestions organizations can use to overcome a variety of barriers and challenges. The list was developed using the experiences of organizations and agencies across the country (Goode, Jones, Dunne & Bronheim, 2007). The first set of lessons learned focuses on leadership. The lesson explains that:

- Leadership must be cultivated at every level of an agency or organization to advance and sustain cultural competence.
- Anyone can be a leader no matter what position in the organization is held.
- Leaders are those who influence others and all leaders are valued and important.
- Traditional leadership roles must adapt to face ongoing and new challenges to the

advancement of cultural competence (Goode, Jones, Dunne & Bonheim, 2007). (This listing makes your sentence easier to read.)

Leadership support and buy-in is imperative to the success of implementation efforts. Once this group is in support of the efforts to implement cultural competence, these leaders are in the position to affect change at every level (Shaw-Taylor, 2002; McPhatter & Ganaway, 2003; Betancourt, Green & Carrillo, 2002). Leaders set the course of an organization, they set the precedent for all who work for that organization, and they control the resources, both monetary and human. "If CEOs and agency administrators are lukewarm about cultural competence, their commitment to the goal will be also. The physical, psychological, and social tone of the organization will follow the leaders' examples" (McPhatter & Ganaway, 2003, p. 109).

The remaining lessons are shared ownership, the 'isms' (sexism, racism, ageism), keeping it real and weaving cultural competency into the fabric of the organization. The following strategies can help overcome barriers and challenges in the process of implementing cultural competence:

- All stakeholders must share an understanding of the implementation process and the benefits of cultural competence.
- Efforts to advance and sustain cultural competence must include everyone to be effective.
- Focus must be placed upon biases, prejudices and discrimination to address health disparities.
- Racism and all other 'isms' must be effectively addressed with integrity.
- Provide opportunities to learn for stakeholders at all levels in order to attain knowledge and skills relevant to cultural competence.

- Redefine job descriptions and functions to ensure they embody all necessary skill and qualities that will allow for culturally competent care.
- Create a system of acknowledgement for staff efforts and achievements toward cultural competence.
- Promote the idea that cultural competence is directly linked to quality patient care.
- Assess progress regularly with established benchmarks (Goode, Jones, Dunne & Bonheim, 2007).

### Methods

The literature related to cultural competence was reviewed to determine the steps necessary for successful implementation and strategies to address any identified barriers, with particular emphasis on health care organizations. Because cultural competence implementation requires organizational capacity for change and strong leadership, these topics were included in the literature review as well. Specifically, key word searches for the following items were reviewed and assessed for support in the literature dated 1988 - present: cultural competence, cultural competency, multicultural, diversity management, health disparities, organizational development, leadership, assessment, process, measurement, tools, implementation, challenges and barriers. The literature review included articles available online using Pubmed Central, CINAHL, Google Scholar, and ISI Citation (Web of Science) databases. These databases were accessed through the University of North Carolina's Health Sciences Library.

General internet searches were also conducted using the Google search engine. One hundred and thirty-three articles and numerous government and foundation reports across disciplines of study were retrieved and abstracts were reviewed to determine the significance of each article to the literature review. Information from 34 articles was determined to be relevant

and was included in this document. In addition to the articles, internet searches returned World Wide Web pages that contained relevant documents. These documents were reviewed to determine their relevance to the literature review.

### Results

The key findings in this research show that self-assessment and leadership buy-in are the two vital components that must be in place for successful implementation of cultural competence standards. Public health was also identified as having an important support role in the process for health care organizations. While the research does not draw a direct connection between cultural competence and improved health outcomes, leaders in the field strongly believe in this correlation despite the absence of hard evidence.

Barriers or challenges to cultural competence identified across disciplines include lack of awareness and attitude, lack of knowledge and skills, and lack of time, resources and organizational support, and there were strategies to address each of the barriers. Addressing the barriers is necessary for successful implementation. Organizations in this research progressed through most stages of both models of delivery but not in a particular prescribed order.

Multiple conceptual frameworks and models to assure cultural competencies were identified, each building on strategies for health improvement and recommendations for action. The role of assurance activities, such as monitoring and evaluating, was noticeably absent from most of the literature, although several authors suggest including the implementation into an organization's quality management structure as important.

### Discussion

If racial and ethnic minorities are unable to access equal and quality health care then why is every health organization not working diligently to change the dynamics within health care to

improve this situation? The numbers of people potentially experiencing health disparities are disturbing and if allowed to continue, could have disastrous effects on entire communities. The CLAS standards provide the push for some agencies to move forward to address health disparities; but for privately held health care organizations, the push will have to come in the form of a lawsuit or perhaps leadership change. Organizations with an eye on the bottom line may create their own push to provide equal access to health care for all members of their communities. The examples within the paper prove that attaining and sustaining cultural competency is not only possible, it is necessary.

The self-assessment process is lengthy and somewhat intimidating to consider in working toward cultural competence within my own organization which is relatively small as compared to some. It is not a stretch to imagine what the process would look like to a senior level manager or chief executive officer who is charged with implementing such a plan for a large scale organization. Cultivating support throughout such an agency could prove to be difficult, especially if the employees feel as though they are overworked without additional responsibilities that invariably accompany such endeavors.

Leadership buy-in and support is certainly a possible stumbling block for organizations. When the suggestion for change is coming from the bottom up, it may be a hard sell to the leadership, especially if the organization is state-wide or even national. Front line workers may see the disconnect between provided services and what the patient actually needs. Communicating that upwardly through the chain of command may prove to be impossible in some cases. Even through a presentation of the business case to leadership, if they are not connected to the communities they serve, the bottom line may not be a strong enough incentive for them to offer up support by way of funding or even allowance of time. Leadership holds the



power in most cases because they control the resources. They can either smooth the way for successful implementation or stop the process entirely.

As a health professional that has worked in public health and non-profit environments for the last 20 years, I can say that for me it began as a lack of awareness, then there was lack of organizational support, and finally lack of time and resources.

When beginning this research project, I was particularly interested in what I could learn to help my organization become culturally competent. I will have to admit, I thought the resistance in my own organization was related to lack of available resources. However, I discovered this to be the furthest from the truth. In reality, with a quick Google search, one can find more than ten completely free cultural competence assessment tools and guidelines. If the search is expanded to include business, human resources, management, and other non-health care fields, there are additional tools and plenty of rationales related to how becoming culturally competent is good for business, particularly in our increasingly diverse society.

Armed with the information, resources, and tools discovered in this research study, along with a well-developed rationale, I plan to present the following recommendations to Planned Parenthood Health Systems upper management team for consideration during the May 2008 management team meeting. This will allow time for resource allocation to be secured in the upcoming fiscal year's budget. This proposal will include steps of action (as described below) to take in each department and at each level of the organization that incorporates PPFA requirements and helps PPHS meet the growing needs of our increasingly diverse communities. As a member of the management team, I will use my interest and commitment to gain support from other managers to obtain the necessary buy-in and to pave the way for the organizational self assessment. I will take an active role in conducting the self assessment process and seek

ways to actively address identified needs through my work as the Regional Director of PPHS Health Services.

### Recommendations

#### *Planned Parenthood Health Systems*

Planned Parenthood Health Systems, Inc. (PPHS) operates thirteen health centers in four states providing comprehensive reproductive health care and education in North Carolina, South Carolina, Virginia, and West Virginia. PPHS has community educators, public policy advocates and development personnel in each state as well. Of the nearly 20,000 patients seen in 2006 (as indicated on patient registration forms), 67.4% were white, 23.9% black, .0.2% American Indian/Alaskan Native, 1.7% Asian/Pacific Islander, and 1.9% other, and 4.8% Hispanic.

Planned Parenthood Health Systems is an accredited affiliate of Planned Parenthood Federation of America (PPFA). PPFA is the nation's leading sexual and reproductive health care advocate and provider. PPFA, through its affiliate partners, works to improve the sexual health and well-being of individuals and families everywhere and provides sexual and reproductive health care, education and information to five million women, men and adolescents in the United States each year. One in four American women has visited a Planned Parenthood center at least once in her lifetime, and Planned Parenthood is often the only source of family planning for a large portion of the women served ("Planned Parenthood", 2007).

As the nation's leading provider of sexual and reproductive health services, it is essential that all Planned Parenthood affiliates, like PPHS, are working to incorporate cultural competence into organizational programs and policies to effectively respond to the needs of increasingly diverse communities, to increase their competitive edge in the health care market, and to improve the overall quality and accessibility of reproductive health care. When considering the type of

care provided at Planned Parenthood, failure to address cultural competency can lead to unwanted pregnancy (misunderstood directions for use), potential relationship conflicts (encouraging birth control without considering partner's role and possible resistance), and negative health outcomes (barriers to access for pap testing, vaccines, etc).

To encourage and support affiliates in this important work, PPFA released a two-year plan in 2006 for the incorporation of diversity as a requirement for affiliate accreditation. The plan includes recommendations and measures for including diversity in all aspects of Planned Parenthood's organizational structure, services and programs. Over the next few years, affiliates will be evaluated on meeting the requirement of embracing diversity, providing culturally and linguistically appropriate services, and incorporating diversity it into all organizational functions. External pressures, like PPFA accreditation requirements and federal mandates (See Appendices D & E), can be the impetus to beginning the process, but ultimately it must be driven internally by the "want-to."

#### *Recommended Action*

To facilitate this process, PPHS must convene a diversity/cultural competency leadership committee to serve as the primary body for planning, implementing and evaluating the organizational cultural competence efforts. This multi-departmental team must include board members, senior and middle management, clinicians, frontline workers, and volunteers. They will lead efforts toward meeting the diversity indicators and assure cultural and linguistic competency at all levels of the organization. Recommended actions to be taken include:

- Incorporate commitment to diversity and cultural competency into the organization's mission statement, strategic planning processes, recruitment and hiring practices, employee expectations and performance evaluations,

communications, and patient care delivery model.

- Conduct organizational self-assessments to include questionnaires, interviews, and focus groups at the annual all-staff meeting and within each department.
- Review of organization's policies, procedures, working documents and patient related materials to ensure culturally and linguistically appropriate materials and interventions.
- Gather and utilize demographic data (staff, current patients, community) using available data collections systems (public health, internal patient management system, annual PPFA reports) for developing programs, expanding services, creating new positions, and recruiting employees and Board members.
- Establish goals and objectives (needed skills, information, materials, etc) from information gathered, communicate throughout the organization, and create ongoing dialogue regarding progress toward these goals.
- Conduct learning opportunities to explore cultural issues and increase employee's knowledge and skills (ultimately increasing institutional knowledge).
- Secure funding resources for development of educational materials, compliance with CLAS standards, and PPFA accreditation requirements.
- Develop a language access plan and secure resources to assure patient access to PPHS services in multiple languages (set-up contract with language line telephone services, hire interpreters and/or bilingual staff).
- Hire staff that reflect the client population, increase diversity among employees and volunteers, as well as among the leadership team, through revised recruitment and hiring practices.

- Develop mechanisms for feedback from employees, leadership, community members and patients.
- Conduct ongoing assessments, evaluate training program, monitor activities, and apply continuous quality improvement to this process.
- Maintain communications with organization leadership (Board, CEO, Senior management) about activities and progress toward established goals.

Providing culturally competent care and becoming a culturally competent organization is both a journey and a responsibility. To meet this challenge, Planned Parenthood Health Systems (PPHS) will want to consider the recommendations presented above, along with the extensive and readily available Planned Parenthood Federation of America (PPFA) resources. Considering the lessons learned from the many 'exemplary practices' as identified by HRSA and presented in the literature could save PPHS time and money on this journey. Acknowledging that leadership buy-in and support is necessary, PPHS must begin the journey towards cultural competence at the top. PPHS can, with leadership support, available resources, and staff commitment improve access to and quality of essential reproductive health care. Ultimately, by providing culturally and linguistically competent services to patients in the communities they serve, PPHS will be able to improve health outcomes that may eventually reduce health disparities.

#### *Further Study Needed*

The research divulged little information on evaluation of cultural competence programs' impact and outcomes. Without the solid data from studies on this subject, it is hard to convince board members and upper management to expend resources to implement an organizational culture changing program when little evidence exists about the impact. Additional studies are also needed, to explore extending the research to private practices as well as studying the effects

on communities when organizations focused on health choose not to become culturally competent.

## References

- Ahmann, E. (2002). Developing cultural competence in health care settings: National Center for Cultural Competence. *Pediatric Nursing*, 28, 133-137.
- American Psychological Association (2001). *Publication manual of the American Psychological Association, fifth edition*. Washington, DC: APA
- Anderson, L.M., Scrimshaw, S.C., Fullilove, M.T, Fielding, J.E., Normand, J. (2003). Culturally competent health care systems, a systematic review. *American Journal of Preventive Medicine*, 23, 68-77.
- Betancourt, J.R., Green A.R. & Carrillo, J.E. (2002). Cultural competence in health care: Emerging frameworks and practical approaches. *Field Report, October 2002*, The Commonwealth Fund.
- Campinha-Bacote, J (2002) The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care. *Journal of Transcultural Nursing*, 13, 181-184.
- Campinha-Bacote, J. (2003). *The process of cultural competence in the delivery of health care services*. Transcultural C.A.R.E. Associates. Retrieved online on February 29, 2008 from <http://www.transculturalcare.net>
- Child's death: Police confiscate religious materials, computers. (2008). Retrieved online on March 28, 2008 from <http://www.wausaudailyherald.com/apps/pbcs.dll/article?AID=/20080328/WDH0101/80328044&theme=WDHNEUMANN>
- Chinman, M., Imm, P., Wandersman, A., Kaftarian, S., Neal, J., Pendleton, K. & Ringwalt, C. (2001). Using the getting to outcomes (GTO) model in a statewide prevention initiative. *Health Promotion Practice*, 2, 302-309.

Cross, T.L., Bazron, B.J., Dennis, K.W., & Issacs, M.R. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards a culturally competent system of care, volume I*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center

Goode, T.D. & Jackson V.H. (2003). *Getting started and moving on: Planning, implementing and evaluating culturally & linguistically competent systems of care for children and youth needing mental health services and their families*. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development. Retrieved March 2, 2008 from <http://gucdc.georgetown.edu/nccc>

Good, T., Jones, W., & Mason, J. (2002). *A guide to planning and implementing cultural competence organization self-assessment*. Washington, D.C.: National Center for Cultural Competence, Georgetown University Child Development Center.

Health Resources and Services Administration, U.S. Department of Health and Human Services. (2001). *Cultural competence works, Using cultural competence to improve the quality of health care for diverse populations and add value to managed care arrangements*. Retrieved online on March 24, 2008 from <ftp://ftp.hrsa.gov/financeMC/cultural-competence.pdf>

Institute of Medicine Report. (2002). *Unequal treatment: What healthcare providers need to know about racial and ethnic disparities in healthcare*. Retrieved March 23, 2008 from: <http://www.iom.edu/file.asp?id=4175>



- Institute of Medicine. (1988). *The Future of Public Health*. Washington, D.C.: National Academy Press; 1988.
- Leonard, B.J. & Plotnikoff, G.A. (2000). Awareness: The heart of cultural competence. *Clinical Issues, Advanced Practice in Acute Critical Care*, 11, 51-59.
- Linkins, K.W., McIntosh, S., Bell, J., Chong, U. (2002) Indicators of cultural competence in health care delivery organizations: An organizational cultural competence assessment profile. Health Resources and Services Administration, US-DHHS, Accessed online 26 February 2008 at <http://www.hrsa.gov/culturalcompetence/indicators/>
- Mason, J.L. (1995). *Cultural competence self-assessment questionnaire: A manual for users*. Portland, OR. Portland State University, Research and Training Center on Family Support and Children's Mental Health.
- Mays, R.M., de Leon Siantz, M.L. & Viehweg, S.A. (2002). Assessing cultural competence of policy organizations. *Journal of Transcultural Nursing*, 13, 139-141.
- National Prevention Information Network (2008). Cultural Competence (Online). Retrieved March 23, 2008. <http://www.cdcnpin.org/scripts/population/culture.asp>
- Population Clocks (2008). U.S. Census Bureau. Retrieved on March 29, 2008 from <http://www.census.gov/>
- Reid-Rose, L. (n.d.). *An approach for creating a roadmap for the sustainability of cultural competence*. Retrieved online March 26, 2008 at <http://www.ccsi.org/Learning/CulturalCompetency.aspx>
- Rowitz, Louis (2003). *Public health leadership: Putting principles into practice*. Sudbury, MA: Jones and Barlett.
- Shaw-Taylor, Y. (2002). Culturally and linguistically appropriate health care for racial or ethnic

minorities: Analysis of the US Office of Minority Health's recommended standards.

*Health Policy*, 62, 211–221.

Shaw-Taylor, Y. (2002). Role of Public Health in meeting the CLAS standards. *Health Policy*, 62, 211–221.

Sue, D.W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist*, 29, 790–792.

Tools and processes for self-assessment (n.d.). National Center for Cultural Competence.

Retrieved on February 13, 2008 from <http://www11.georgetown.edu/research/gucchd/nccc/foundations/assessment.html>

U.S. Census Bureau (2000) Retrieved on March 23, 2008 from <http://www.census.gov/>

Van Ngo, H. (2000). Cultural competency: A self-assessment guide for human service organizations. Alberta, Canada: Cultural Diversity Institute.

Zambrana, R.E., Molnar, C., Munoz, H.B., Lopez, D.S. (2004). Cultural competency as it intersects with racial/ethnic, linguistic, and class disparities in managed healthcare organizations. *Special Issue: The American Journal of Managed Care*, 10, 37–44.

## Appendix A



## Cultural Competence Self-Assessment



The following self-assessment will assist you to explore your cultural competence in the areas of self-exploration and knowledge of the dimensions of diversity, linguistic competence, and organizational competence. It is a short, easy to use tool that can be incorporated into your diversity work with staff, boards, or other volunteers. It is one of many tools available to you in your ongoing journey toward cultural competence. Please feel free to use it as needed, and enjoy the process!

<b>Individual self-assessment: How familiar am I with . . .</b>		<b>Very Familiar</b>	<b>Somewhat Familiar</b>	<b>Not Familiar</b>
1.	the aspects of my own cultural identity I feel strongest about and why?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	white, male, heterosexual, and/or Christian privilege and how they impact my interaction with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	the reasons many people of color are distrustful of health care institutions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	what culturally competent services are?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.*	why the phrase "sexual orientation" is more accurate than "sexual preference"?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	why it is important to know the immigration and migration patterns in my area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.**	why the phrase handicapped is offensive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	what internalized oppression is and what it looks like?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.***	why "color-blindness" in relation to race recognition is a myth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	why the phrase "reverse discrimination" is inaccurate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Linguistic competence: How often do I . . .</b>		<b>Frequently</b>	<b>Occasionally</b>	<b>Seldom</b>
1.	learn and use key phrases to better communicate with clients, staff, and volunteers who speak other languages?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	collaborate with bilingual staff or trained volunteers to serve as interpreters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	create notices and correspondence to clients, staff, and volunteers for whom English is a second language in their language of origin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Organizational competence: How often do I . . .</b>		<b>Frequently</b>	<b>Occasionally</b>	<b>Seldom</b>
4.	avoid imposing values that may conflict or be inconsistent with other cultures or ethnic groups?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	learn the courtesies, customs, and expectations that are culturally-specific to the communities in which my agency provides services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	advocate for program and agency goals, policies, and procedures that promote cultural diversity and cultural competence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	listen actively and reflect on my relationship with clients, staff, and volunteers who are both similar to and different from me?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	discourage others from using offensive comments about diverse groups by helping them understand that regardless of their intent the impact can be hurtful to others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	screen books, videos, and other material for negative stereotypes before using them in my agency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	reference sources for culturally competent healthcare offered in my affiliate, the national office, or other organizations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

This tool is meant to encourage self-discovery. If you choose to hold a discussion after using it, you may find the following principles useful as you explore the cultural competence self-assessment questions.

**Embracing diversity is a life-long journey.**

- **One size does not fit all.** The nature of a diversity initiative in the northeast corner of Vermont may be very different from one in southern Texas.
- **We are one another's teachers and students.** We are all on this journey together and will support, teach, and learn from one another's experiences and insights. In addition, we recognize that we may need to engage outside experts to work with us.
- **Creating safe conditions for embracing diversity is essential.** Some variables that guide the creation of safe conditions include
  - mutual agreements for behavior
  - ongoing individual-to-individual contact and discussion
  - affirmation and appreciation of cultural differences and similarities
  - development of allies across identity groups
  - creativity and fun with the work
  - leadership development
  - an atmosphere of learning
- **Healing is vital for those who have lost faith in the process.** We need to regain confidence in our ability to make significant progress together toward creating a truly diverse organization. Creating systemic change requires a critical mass of diversity activists supporting one another.

*Source: The Diversity Strategic Plan for Planned Parenthood Federation of America, 2002-2006*

**Things to consider . . .**

- 5.\* "Sexual orientation" reflects the complexity of factors that determine to whom we are sexually attracted and with whom we fall in love. It is different from sexual behavior; since one's sexual behavior may not match one's innate sexual orientation.
- 7.\*\* The term "handicapped" is outdated, and connotes that people with disabilities need charity. Disabilities don't handicap; attitudes and architecture handicap. Some people prefer the term "differently-abled".
- 9.\*\*\* Saying that one is "color blind" in reference to race recognition denies the existence of racism, and ignores the existence of white privilege. As such, it protects these privileges from being fully acknowledged and addressed.

## Related Diversity Resources

**The PPFA Diversity Department Publications**

- *Cultivating Diversity: Organizing Within and Without (brochure)*
- *Enhancing Cultural Competence: Welcoming the Lesbian, Gay, Bisexual, and Transgender Community (tool kit)*
- *Diversity Strategic Plan for Planned Parenthood Federation of America, 2002-2006 (booklet)*

**Websites**

- Advocates for Youth at [www.advocatesforyouth.org](http://www.advocatesforyouth.org)
- The Human Rights Campaign Foundation at [www.hrc.org/worknet](http://www.hrc.org/worknet)
- National Center for Cultural Competence at [www.georgetown.edu/research/guec/nccc/index.html](http://www.georgetown.edu/research/guec/nccc/index.html)
- Office of Minority Health Resource Center at [www.omhrc.gov/omhrc](http://www.omhrc.gov/omhrc)

For more information or related materials, contact [diversity@ppfa.org](mailto:diversity@ppfa.org).

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## Appendix B

Tawara D. Goode\*Georgetown University Center for Child and Human Development\*Adapted from *Promoting Cultural Competence and Cultural Diversity for Personnel Providing Services and Supports to Children with Special Health Care Needs and their Families* \* June 1989. (Revised 1993, 1996, 1997, 1999, 2000 & 2002, & 2004).

**Directions:** Please select A, B, or C for each item listed below.

A = Things I do frequently

B = Things I do occasionally

C = Things I do rarely or never

- \_\_\_\_\_ 1. I display pictures, posters, artwork and other decor that reflect the cultures and ethnic backgrounds of clients served by my program or agency.
- \_\_\_\_\_ 2. I ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures and languages of individuals and families served by my program or agency.
- \_\_\_\_\_ 3. When using videos, films or other media resources for health education, treatment or other interventions, I ensure that they reflect the culture and ethnic backgrounds of individuals and families served by my program or agency.
- \_\_\_\_\_ 4. I ensure that printed information disseminated by my agency or program takes into account the average literacy levels of individuals and families receiving services.
- \_\_\_\_\_ 5. When interacting with individuals and families who have limited English proficiency I always keep in mind that:
  - \_\_\_\_\_ \* limitations in English proficiency is in no way a reflection of their level of intellectual functioning.
  - \_\_\_\_\_ \* their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.
  - \_\_\_\_\_ \* they may neither be literate in their language of origin nor in English.
- \_\_\_\_\_ 6. I use bilingual/bicultural or multilingual/multicultural staff, and/or personnel and volunteers who are skilled or certified in the provision of medical interpretation services during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance.
- \_\_\_\_\_ 7. For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words so that I am better able to communicate with them during assessment, treatment or other interventions.
- \_\_\_\_\_ 8. I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment, health promotion and education or other interventions.
- \_\_\_\_\_ 9. For those who request or need this service, I ensure that all notices and communiqués to individuals and families are written in their language of origin.
- \_\_\_\_\_ 10. I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method of receiving information.

- \_\_\_\_\_ 11. I understand the principles and practices of linguistic competency and:  
  
\_\_\_\_\_ \* apply them within my program or agency.  
  
\_\_\_\_\_ \* advocate for them within my program or agency.
- \_\_\_\_\_ 12. I understand the implications of health literacy within the context of my roles and responsibilities.
- \_\_\_\_\_ 13. I use alternative formats and varied approaches to communicate and share information with individuals and/or their family members who experience disability.
- \_\_\_\_\_ 14. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
- \_\_\_\_\_ 15. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with individuals and families served by my program or agency.
- \_\_\_\_\_ 16. I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors that show cultural insensitivity, racial biases, and prejudice.
- \_\_\_\_\_ 17. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.
- \_\_\_\_\_ 18. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).
- \_\_\_\_\_ 19. I accept and respect that male-female roles may vary significantly among different cultures e.g. who makes major decisions for the family).
- \_\_\_\_\_ 20. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).
- \_\_\_\_\_ 21. Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.
- \_\_\_\_\_ 22. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.
- \_\_\_\_\_ 23. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease, and death.
- \_\_\_\_\_ 24. I understand that the perception of health, wellness, and preventive health services have different meanings to different cultural groups.
- \_\_\_\_\_ 25. I recognize and understand that beliefs and concepts of emotional wellbeing vary significantly from culture to culture.
- \_\_\_\_\_ 26. I understand that beliefs about mental illness and emotional disability are culturally-based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.
- \_\_\_\_\_ 27. I recognize and accept that folk and religious beliefs may influence an individual's or family's reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic

disorder, or special health care needs.

- \_\_\_\_\_ 28. I understand that grief and bereavement are influenced by culture.
- \_\_\_\_\_ 29. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.
- \_\_\_\_\_ 30. I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my program or agency.
- \_\_\_\_\_ 31. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally diverse groups served by my program or agency.
- \_\_\_\_\_ 32. I keep abreast of the major health and mental health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my program or agency.
- \_\_\_\_\_ 33. I am aware of specific health and mental health disparities and their prevalence within the communities served by my program or agency.
- \_\_\_\_\_ 34. I am aware of the socio-economic and environmental risk factors that contribute to health and mental health disparities or other major health problems of culturally and linguistically diverse populations served by my program or agency.
- \_\_\_\_\_ 35. I am well versed in the most current and proven practices, treatments, and interventions for the delivery of health and mental health care to specific racial, ethnic, cultural and linguistic groups within the geographic locale served by my agency or program.
- \_\_\_\_\_ 36. I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, and linguistically diverse groups.
- \_\_\_\_\_ 37. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

#### **How to use this checklist**

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic cultural competence in health, mental health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices which foster cultural and linguistic competence at the individual or practitioner level. There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate beliefs, attitudes, values and practices that promote cultural and linguistic competence within health and mental health care delivery programs.

## Appendix C

**CONDUCTING A CULTURAL COMPETENCE SELF-ASSESSMENT**

Developed by Dennis Andrulis, Thomas Delbanco, Laura Avakian and Yoku Shaw-Taylor

**PURPOSE**

There are several reasons why a healthcare organization may wish to conduct an audit of its cultural competence. First, it may want to validate its understanding of the ethnic and cultural composition of its patient and employee populations. Further, it may seek to identify the unique attributes of a given cultural group to ensure access, appropriate treatment and effective communication between providers and patients. Additionally, the audit may reveal opportunities for the organization to make itself more attractive to diverse populations, thereby enhancing its marketing capabilities as well as strengthening its ties to community. Most important, the very act of conducting the self-assessment is a statement to the workforce, patients and community that the organization values diversity and desires to increase its cultural competence.

**HOW TO CONDUCT THE SELF-ASSESSMENT***A. Create a task force of stakeholders*

Ultimately, quite a number of people will be involved in the process because you will want to scan the breadth and depth of the organization. However, the audit should be led by a small committee that represents certain key functions or departments. A typical self-assessment team consists of 8 to 12 people. On the audit team should be individuals who can access and interpret data addressing the composition of the patient and staff population. Team members may come from finance, admitting, patient registration, human resources, information systems, or administration. Additionally, there should be individuals whose jobs are directly concerned with ethnic/cultural issues, i.e. diversity coordinators, translators/interpreters, social workers, community relations and employee relations specialists, and clergy. Different clinical disciplines should also be represented: doctors, nurses, therapists. The team may benefit by inviting patients or representatives of your community as members. The team itself should also reflect ethnic/cultural diversity.

*B. Select a task force leader*

Who serves as leader of the assessment team is an important decision. He or she should be an individual, who is well-positioned within the organization—one who has access to people at all levels and information from all sources. He or she must be credible, respected, and generally regarded as sensitive to diversity issues. Equally important is the explicit support for this initiative from the CEO and other prominent leaders. They can demonstrate such support through written and verbal communication, as well as by devoting time and other resources needed to conduct the audit.

**STEPS IN THE SELF-ASSESSMENT PROCESS**

There are generally five steps in the self-assessment. However, organizations will vary the time spent or depth of inquiry at various stages of the process.

*Step 1 Organization*

- (a) The CEO appoints the team leader and task force.
- (b) CEO and other organizational leaders affirm the project team's charter.
- (c) The task force develops a timeline for the entire project.



(d) Individual task force members take assignments.

*Step 2 Completing the Questionnaire*

(a) Task force members determine who is best able to complete each section of questionnaire and takes responsibility for its completion.

(b) Task force members discuss what supplementary materials may support the information provided in the questionnaire (e.g. patient information pamphlets) and take responsibility for obtaining them.

*Step 3 Interviews*

(a) The task force reviews and discusses findings from the questionnaire. Based on those results, the task force determines what individual or group interviews should be conducted to explore further some issues identified in the questionnaire or to clarify areas that are ambiguous.

(b) Members of the task force decide who will complete each of the interviews. (Possible interview subjects and exploratory questions are suggested below.)

*Step 4 Evaluation of Results*

(a) The task force reviews the data from the questionnaire and the interviews.

(b) Drawing on the data and analyses, the team decides where the organization fits along the "spectrum of cultural competence."

*Step 5 Report and Action*

(a) Depending on the charge given the team in Step 1, the task force discusses its findings with multiple audiences. These findings are often offered in a written report to the CEO or a Board committee.

(b) In addition to a self-assessment of overall cultural competence, the report will likely include specific recommendations for actions to be taken, identifying who would be accountable for taking the actions.

## Appendix D

### **National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care** ***Culturally Competent Care:***

1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that sta. at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

### ***Language Access Services:***

4. Health care organizations must offer and provide language assistance services, including bilingual sta. and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/ consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

### ***Organizational Supports:***

8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction Assessments, and Outcomes-Based Evaluations.
10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/ consumer involvement in designing and implementing CLAS-related activities.
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS Standards and to provide public notice in their communities about the availability of this information.

## Appendix E

### **Title VI of the Civil Rights Act of 1964**

#### **The Law**

*No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, or be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.*

#### **What the Law Means**

Any agency or organization that receives any federal funding is required to provide interpreters for persons of limited English proficiency (LEP) in *all* its programs and services. The agency must do this at its own expense. That is the consistent interpretation of Title VI that has been applied by the Office for Civil Rights of the U.S. Department of Health and Human Services (HHS). The law also applies to private practitioners who accept clients with Medicare or Medical Assistance.

**Most health organizations receive at least some federal funding, whether they receive the money directly or filtered down through a state or local agency. Title VI therefore applies to most health care organizations that offer family planning services.**

#### **Other Laws**

Other laws require that health providers offer interpreters to clients. Some of these laws are: The Hill- Burton Act (1946), Medicaid and Medicare, Federal Categorical Grant Programs, Emergency Medical Treatment and the Active Labor Act. In addition, there are recent changes in state laws, such as in Maryland about language access.

#### **What Is the Reality?**

The reality is that most health and human service organizations do not provide interpreters. Those that do so often have no (or very few) trained interpreters. Resources are scarce. Trained interpreters are also scarce.

#### **What Should Happen in an Ideal World?**

Larger health organizations are expected to hire and train bilingual staff whenever possible. Where that is not feasible, they should contract with community-based language banks of trained interpreters, build their own language bank of interpreters and offer training, or secure other interpreter resources to call upon in times of need.

**The law does allow more latitude (and lenience) for small organizations than hospitals and other large organizations. Still: no agency that receives federal funding is exempt from the law.**

## TITLE VI AND INTERPRETERS

### What Should a Reproductive Health Organization Do?

If your organization receives any form or stream of federal funding it is required to:

1. Inform the LEP client of his or her right to a free interpreter
2. Post signage in the dominant languages of LEP clients stating their right to an interpreter
3. Schedule every appointment for an LEP client with an interpreter. (Trained interpreters and trained bilingual staff are preferred)
4. If the client refuses your interpreter, document that refusal in the client's file
5. You may wish to bring in a trained interpreter even after such a refusal, for the protection of all concerned. The interpreter would then intervene only if the client's interpreter makes an error. (Errors are almost inevitable, however, with untrained interpreters)
6. Use telephonic services or other backup resources to schedule appointments, answer phone calls from LEP clients and handle emergencies
7. Do not allow children to interpret

It is important not to ask the client to bring an interpreter. In essence, that is considered discriminatory and thus a violation of the law. Allowing minors to interpret is also strictly prohibited, as it is potentially harmful for both child and client. While the Federal government does not demand the use of trained interpreters, the HHS Office for Civil Rights emphatically recommends using trained interpreters due to the risks caused by the inaccuracy and bias of untrained interpreters—and also to safeguard confidentiality.

For more details and the official guidance and wording, see <http://www.hhs.gov/ocr/lep/guide.html>

Source: Cultural Competence, a guide for family planning cultural competence, prepared by *TRAINING 3 of Family Planning Council, Inc.* Virginia Department of Health, accessed on 28 March 2008 at [www.vdh.virginia.gov/CLAS\\_Act/culturallyappropriate/documents/familyplanningcc.pdf](http://www.vdh.virginia.gov/CLAS_Act/culturallyappropriate/documents/familyplanningcc.pdf)

